3 Personal Care Service Guidelines

3.1 Introduction

3.1.1 Overview

This section covers all Medicaid services provided under Personal Care Services (PCS).

For adults receiving services under the State Medicaid Plan Option, service delivery is limited to a maximum of sixteen (16) hours per week per participant. For individuals who meet medically necessity criteria under Early, Periodic Screening, Diagnosis, and Treatment (EPSDT),as found in IDAPA 16.03.09.536, the participant may receive up to twenty-four (24) hours per day of service delivery through the month of his/her twenty-first birthday. The services must be medically necessary and meet the other program requirements found in IDAPA 16.03.09.146.

All PCS must be provided in accordance with a written plan of care.

Facilities known as "24 hour PCS homes" are available only for children. All such facilities that serve adults are considered Adult Residential Care under the HCBS waiver.

Note: Personal Care services are covered for Medicaid **Enhanced** Plan participants.

Note: Personal Care services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

Note: Personal Care services are covered for **Medicaid Enhanced Plan** participants

3.1.2 General Information

This section covers all general claims information for PCS Services.

It addresses the following:

- Provider qualifications
- Record keeping
- Prior authorization
- Healthy Connections
- Dates of service
- Service description
- Claim billing

3.1.2.1 Provider Qualifications

All providers of services must have a valid provider agreement or performance contract with Medicaid. Individual providers must meet the qualifications of IDAPA 16.03.09.146. Performance under this agreement or contract will be monitored by the Regional Medicaid Services Unit (RMS) in each region.

A separate provider number for transportation services must be obtained by PCS providers and agencies.

3.1.2.2 Record Keeping

Medicaid requires all providers to meet the documentation requirements listed in the provider enrollment agreement and IDAPA rules. Providers must generate records at the time of service and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement.

Retain all medical records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

3.1.2.3 Prior Authorization (PA)

The RMS must authorize all services reimbursed by Medicaid under the PCS program prior to the payment of services. Approved PAs are valid for the dates shown on the authorization. If PA is required, the PA number must be indicated on the claim.

See **General Billing Section 2.3** for more information on PAs.

3.1.2.4 Healthy Connections

Healthy Connection referrals are **not** required for services under the PCS program.

3.1.2.5 Dates of Service

Dates of service must be within the Sunday through Saturday calendar week on a single detail line on the claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Failure to comply with the Sunday through Saturday billing will result in claims being denied. In addition, one detail line on a claim form cannot span more than one calendar month. If the end of the month falls in the middle of a week, two separate detail lines must be used.

For example: See the calendar below. The last week in April 2010 begins Sunday, April 25, and ends Saturday, May 1. Two separate details or lines must be entered on the claim form for this week. One line will have service dates of 4/25/2010 through 4/30/2010. The second line will have service dates of 5/01/2010 through 5/01/2010. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim detail line as long as the same quantity of services has been provided each day.

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
April 2010				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	**May 1**

3.2 Service Description

The PCS provider is referred to as a personal assistant and is responsible for medically oriented tasks related to a participant's physical care provided in the home. Such services must be included in an approved plan of care and include, but are not limited to, the following:

- Personal hygiene – The personal assistant assists the participant with or performs basic personal care and grooming that may include bathing, hair care, assistance with clothing and dressing, bathroom assistance, and basic skin care. The personal assistant may assist the participant with bladder or bowel requirements, which may include helping the participant to and from the bathroom or assisting the participant with bedpan routines.
- Medications – The personal assistant may assist the participant with physician ordered medications that are ordinarily self-administered.
- Meal Preparation – The PCS personal assistant may assist with food, nutrition, and diet activities including meal preparation if the physician determines the participant has a medical need for such assistance. Gastrostomy tube feedings may be performed if authorized by the RMS and the supervising nurse has properly trained the provider personal assistant. Personal assistants may be authorized to perform nasogastric tube feedings if authorized by the RMS and if it meets the requirements in IDAPA 16.03.09.146.01.vi 04.f.
- Household Services – The personal assistant may perform such incidental household services the physician determines to be essential to a participant's comfort, safety, and health. Those services include:
    - Changing of bed linens for the participant.
    - Rearranging of furniture to enable the participant to move about more easily.
    - Doing laundry for the participant.
    - Cleaning of areas used by the participant when required for the participant's treatment.
    - Accompanying the participant to clinics, physician's office, or other medical appointments.
    - Shopping for groceries or other household items required specifically for the health and maintenance of the participant.
- Independence Training – The personal assistant may assist the developmentally disabled participant in the home setting, through the continuation of active treatment training programs to increase or maintain participant independence. Independence training is part of the participant's everyday care. A Qualified Mental Retardation Professional (QMRP) must specifically identify such services on the PCS plan of care. Examples of independence training are: personal hygiene, getting dressed, or taking the participant grocery shopping.
- It is the responsibility of the PCS provider to notify either the supervising registered nurse or the physician when there is a significant change in the participant's condition. Notification of the physician or registered nurse must be documented in the progress

notes. The personal assistant will document any changes noted in the participant's condition or any deviation from the plan of care.

3.2.1 Exclusions

Under no circumstance is the personal assistant authorized to perform any of the following:

- Irrigation or suctioning of any body cavities which require sterile procedures
- Application of sterile dressings
- Administration of prescription medication including injections of fluids into the veins, muscles or skin
- Procedures requiring aseptic technique
- Skin care which requires sterile technique
- Insertion or irrigation of catheters
- Cooking, cleaning or laundry for any other occupant of the participant's residence

Note:

Personal assistants may **not** bring children into a participant's home when providing services.

3.2.1.1 Transportation

Non-medical transportation, such as to the grocery store, is not reimbursable to the personal assistant.

3.2.2 Diagnosis Code

Enter the ICD-9-CM code **V604 – No Other Household Member Able to Render Care**, for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.2.3 Place of Service Code

PCS services may only be provided in a participant's personal residence.

Use place of service code **12 – Home** to indicate the participant's for the place of service on the claim. Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

The following are specifically **excluded** as personal residences:

- Licensed skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or hospitals
- Licensed intermediate care facilities for the mentally retarded (ICF/MR)
- Intensive treatment facility for children as described in Department Rules at IDAPA 16.06.01.620
- A home receiving payment for specialized foster care, professional foster care, or group foster care for children

See **Section 3.2.7.1** for more on the QMRP and special requirements for individuals with developmental disabilities.

3.2.4 Plan of Care

Delivery of all PCS services is based on a written plan of care. The Personal Assistance Agency and the participant are responsible to prepare the plan based on:

- Information from the Uniform Assessment Instrument (UAI) completed by the RMS
- Service hours authorized by the RMS

- Information elicited from the participant
- Information from the QMRP

A copy of the most current plan of care must be kept in the participant's home. The plan must include all aspects of personal care necessary to be performed by the personal assistant, including the amount, type, and frequency of such services.

Services performed, which are not contained in the approved plan of care, are not eligible for Medicaid payments. Failure to follow the approved plan of care may result in loss of payment, provider status for Idaho Medicaid, or other action as deemed necessary by IDHW.

The plan of care must be revised and updated based upon treatment results or a participant's changing needs as necessary, or at least annually. Services performed, which are not contained in the plan of care, are not covered.

3.2.5 Registered Nurse (RN) Responsibilities

An RN, who is not functioning as the personal assistant, may supervise the delivery of PCS to the participant. The supervising RN may be an employee or contractor of a personal assistance agency or fiscal intermediary. The supervisory nurse will:

- Develop a plan of care for the participant.
- Supervise the treatment given by the personal assistant.
- Conduct on-site interviews with the participant as specified in the plan of care.
- Update the plan of care as necessary or at least annually.
- Notify the physician immediately of any significant changes in the participant's physical condition or response to the service delivery.
- Evaluate changes of condition when requested by the personal assistant, case manager, or participant through on-site visits.

Note: PCS organizations should refer to Section 3 for Nursing Services on the *Idaho Medicaid Provider Handbook CD* for their employee or contractor RN Supervisor.

Note: PCS Supervisory RN services are covered for Medicaid **Enhanced Plan** participants.

3.2.6 Special Requirements for Individuals with Developmental Disabilities

In addition to the RN's supervisory visit, some participants who are developmentally disabled (DD) as determined by the RMS, receive an assessment and supervision of service delivery from a QMRP as defined in 42 CFR 442.401.

Note: PCS QMRP services are covered for Medicaid **Enhanced Plan** participants.

3.2.6.1 Qualified Mental Retardation Professional (QMRP) Responsibilities

The QMRP performs the following services:

- Assists in the development of the plan of care for the participant in conjunction with the supervisory RN.
- Supervises the skills training components of service given by the personal assistant. The skills training is generally the continuation of an active treatment program developed by a Developmental

Disabilities Agency or special education department of a school system.

- Conducts participant interviews in the home, as specified in the plan of care.
- Re-evaluates the plan of care annually or as needed.
- Conducts on-site evaluations of changes in participant condition when requested by the personal assistant, case manager, participant, or RN supervisor.

3.2.6.2 RN and QMRP

For adults, the RN and QMRP may provide either supervision or direct participant care but not both. A supervisory visit may be provided every 90 days or as specified in the plan of care.

For children, the RN or QMRP must submit a report of initial assessment and plan of care to the RMS to receive PA to submit a claim for the service. The RMS may also require additional information as necessary.

3.2.7 Functional Assessment / Individual Support Plan Uniform Assessment Instrument

For children, the Functional Assessment/Individual Support Plan is used for assessment and plan development.

The Functional Assessment/Individual Support Plan (HW0614) is in two parts. All pages of the Functional Assessment/Individual Support Plan form must include the participant's name and Medicaid identification (MID) number.

The first three pages of the HW0614 contain the medical and social data to be used in helping to identify the participant's social and medical status, and living situation. **To ensure confidentiality**, these pages must **not** be placed in the participant's home.

Pages four through nine of the HW0614 are the individual support plan. Copies of these pages must be maintained in the home for use by the personal assistant.

After the Functional Assessment/Individual Support Plan is completed, the RN supervisor:

- recommends the number of PCS hours required
- completes any other forms needed
- obtains the participant's or representative's signature on the self-declaration on the last page of the form
- obtains the attending physician's signature as required
- delivers the packet to the RMS for review

The RN supervisor of the personal assistance agency bills for participant evaluation and PCS Functional Assessment /Individual Support Plan development for this service.

For adults, the UAI is the tool used for assessment and as an aid in plan development.

The UAI is administered by the RMS to determine the participant's medical and social history and assess the need for services

The assessment is sent to the personal assistance agency selected by the participant. The agency uses the assessment to write the plan of care. All areas addressed in the UAI must be contained in the plan of care. The agency will obtain the physician's order for services.

3.2.8 Procedure Codes

Medicaid uses the federally mandated HCPCS procedure coding system. All claims must use one of the following five-digit HCPCS procedure codes when billing for personal care services.

Service	Old Code (Prior to 10/20/03)	HCPCS Code (as of 10/20/03)	Description
Supervisory RN Codes			
PCS Assessment - Participant Evaluation & Care Plan Development — Agency	0501P	G9002	*Coordinated Care Fee, Maintenance Rate* Initial visit and/or plan development, and annually for the re-evaluation. Prior authorization (PA) from RMS is required each time this procedure code is used. If additional evaluations are necessary, obtain PA from the RMS. For adults, 1 unit = 1 plan development. For children, 2 units = 1 assessment and 1 plan development.
RN Supervising Visit — Agency	0503P	T1001	*Nursing Assessment/Evaluation* The frequency of the supervising visits will be included in RMS approved PA. If additional or emergency visits in excess of the approved number are required, they must be prior authorized by the RMS. 1 unit = 1 visit
QMRP Codes			
QMRP Participant Evaluation and Individual Support Plan Development – Agency	0513P	G9001	*Coordinated Care Fee – Initial Rate* Initial visit and plan development and the re-evaluation done annually. PA from the RMS is required each time this procedure code is used. If additional evaluations are necessary, obtain PA from the RMS.
QMRP Supervising Visit - Agency	0514P	H2020	*Therapeutic Behavioral Services, per diem*. The frequency of the supervising visits will be included in the RMS approved PA. If additional or emergency visits in excess of the approved number are required, they must be prior authorized by the RMS. 1 unit = 1 visit

Service	Old Code (Prior to 10/20/03)	HCPCS Code (as of 10/20/03)	Description
Agency PCS Providers			
Agency PCS Provider	0541P	T1019	*PCS, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the Individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse).* 1 unit = 15 minutes
Agency PCS- 24-Hour Care One Participant or Daily Rate for 8.25 - 24 hrs.	0641P	S5145 U3 modifier required	*Foster care, therapeutic, child; per diem* This service is available only to children under the EPSDT benefit. 1 unit = 1 day
Independent PCS 8.25 – 24 hr. participant, Providers home (no withholding)	0643P	S5145	*Foster care, therapeutic, child; per diem* This service is available only to children under the EPSDT benefit. 1 unit = 1 day
Agency PCS- Two Participants, 24-Hour Care Daily Rate for 8.25 - 24 hrs.	0741P	S5145 U3 and HQ modifier required	*Foster care, therapeutic, child; per diem* This code is used when billing for **each** participant when two persons are cared for on the same day. This service is available only to children under the EPSDT benefit. 1 unit = 1 day
Independent PCS Providers			
Independent PCS - Two Participants Daily Rate for 8.25 – 24 hrs. Provider's home (no withholding)	0743P	S5145 HQ modifier required	*Foster care, therapeutic, child per diem* This code is used when billing for **each** participant when two persons are cared for at the same time. This service is available only to children under the EPSDT benefit. 1 unit = 1 day

3.2.9 Record Keeping

A personal care service record (progress notes) must be filled out and maintained for each participant receiving services. A copy of the record must be kept in the participant's home, unless the RMS authorizes another site. The personal assistant must keep the original for the personal assistant's records. Do **not** attach progress notes to claims submitted to EDS.

After every visit the personal assistant will enter, at a minimum, the following information:

- The date of the visit in the format: 02/10/2005.
- The time in and time out for the visit in the format: 8:00 a.m. - 11:15 a.m.
- The length of the visit (total hours): ***Example:*** 3.25 hours.
- The services provided during the visit. **If "other" is marked, a narrative must be provided**.
- A statement of the participant's response to the services including any changes noted in the participant's condition.

- Any changes in the plan of care authorized by the referring physician or supervising RN as the result of changes in the participant's condition.
- The participant's signature on the PCS record, unless the RMS determines that the individual is unable to sign.

3.2.10 Change In Participant Status

The personal assistance agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the personal assistance agency record.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.3.2.1 Guidelines for Electronic Claims

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring provider's Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's HC referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one PA number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

The CMS-1500 form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.3.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 83755
Boise, ID 83707

3.3.3.3 Completing Specific Fields

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection ~~participant~~. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, year). **Example:** November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.

Field	Field Name	Use	Directions
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.3.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500